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NORTHUMBERLAND & DURHAM  
MEDICAL SOCIETY.

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FEBRUARY 12 AND MARCH 12, 1885.

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# NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

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THE FIFTH MONTHLY MEETING was held in the Library of the Newcastle-on-Tyne Infirmary, on Thursday, February 12th, 1885—the President (Dr. Fielden) in the chair.

## DISCUSSION ON THE PREVALENT DISEASES OF THE DISTRICT.

Mr. HENRY E. ARMSTRONG presented the following:—

*Return of Admissions to and Deaths at the Newcastle Fever and Small-pox Hospitals during the month of January, 1885.*

Disease.	Admissions.	Deaths.
Small-pox.....	3 .....	0
Enteric Fever.....	3 .....	1
Scarlet Fever.....	3 .....	0
Total.....	9 .....	1

Dr. GAMMAGE said that he heard from various sources that measles was very prevalent in the borough. There was also some scarlatina. He had had some cases of measles, and he understood from other medical men that the disease was of a bad type. He had read that in Southwick, which might be considered a suburb of the borough, the death rate had been at the rate of more than 60 per thousand, of which the greatest cause was measles.

Dr. BARRON stated that the small-pox epidemic had well nigh subsided in Durham.

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## PATHOLOGICAL TRAY.

### PRIMARY MALIGNANT DISEASE OF MESENTERIC GLANDS.

Dr. PHILIPSON presented a specimen of malignant tumour of the mesenteric glands. The patient, an auctioneer's assistant, aged 56, was admitted into the Newcastle-upon-Tyne Infirmary, on November 22nd, 1884, complaining of very severe pain, commencing in the right lumbar region, and passing across the front of the abdomen to a corresponding point on the opposite side, of six months' duration. He was emaciated, and his conjunctivæ were straw-coloured. His habits had been temperate; he had suffered three times from rheumatic fever; he had not had syphilis.

When his abdomen was inspected, pulsation in the epigastric and umbilical regions was recognised ; and on palpation a somewhat hard, resistent body, coming down as low as the umbilicus, was felt in the right hypochondrium and epigastrium. This felt rough on the surface, but was not nodulated. On the left side of the mass, pulsation was felt, which was non-expansile. Upon auscultation in the left vertebral groove, nothing was heard. The liver extended to a little beyond the costal border, in the right nipple line. A mitral systolic murmur was heard, conducted towards the axilla. The pain was mitigated by the exhibition of bromide of potassium, and the hypodermic injection of morphia. He gradually sank, and died on January 4th, 1885. At the autopsy, the liver was found to be congested, nutmeg in appearance, and on its under surface two nodules were seen. The anterior margin was unusually thin, and was spread over the upper portion of a tumour, which was situated in front of the spine, and was about the size of a child's head at birth. This tumour was glandular, and had attached to its left side the pancreas, and in front the pylorus of the stomach, with the duodenum. In some places it was soft and at others firm. On section, it was rather firm and dry, very little juice being seen, of a pale cream colour. The aorta was beneath the tumour. On microscopical examination cancer cells were seen.

The left lung was consolidated at its upper lobe ; its section showed tubercle in various stages. There were some small cavities, cheesy nodules, and grey tubercles. The lower lobe was congested. The right lung, in its upper lobe, had two tubercular nodules. There was no softening.

The aortic valves showed some thickening around the attached margins. The left auriculo ventricular orifice was somewhat narrowed ; it admitted the tips of two fingers. There was thickening of the mitral curtains, otherwise the heart was healthy.

The chief interest of the specimen was in the differential diagnosis of a tumour situated in front of the abdominal aorta from aneurism. The non-existence of aneurism was inferred from the absence of bruit in the left vertebral groove, and the pulsation being non-expansile. The existence of cachexia was in favour of malignant disease. The eye of the patient strengthened this supposition. The smoothness of the surface of the liver, and its uniform edge, indicated that the swelling was glandular, rather than associated with that organ. Another point of interest was the co-existence of malignant disease, with tubercle—cancer and tubercle being regarded as antagonistic one to the other. The nodules on the under surface of the liver were regarded as secondary, or consequential on the glandular condition—primary cancer of the glands being rare, while secondary cancer is not uncommon.

## CIRRHOSIS OF LIVER IN A YOUTH AGED 17.

Dr. ADAMSON said : The liver and spleen which I show you were removed from the body of a boy aged 17. I first saw him about two years ago on account of biliary disorder, accompanied from time to time with jaundice. A year ago I observed the nodular feeling of the liver, and hesitated to diagnose cirrhosis on account of the boy's age ; especially as his father, a strictly temperate man himself, said the boy had not been fond of or taken alcohol, spices, or stimulating food. The condition of the spleen (which is much enlarged) was first noted three months prior to death. During the last two months of his life he had a great craving for pickles and stimulating food, but he never asked for alcohol in any form. The liver, when fresh, showed well-marked nodules, and over the surface there were a number of spots which are best described as having the appearance of pearls stained with bile. The rarity of the disease in one so young is my excuse for showing these specimens to the society.

## GRANULAR KIDNEY FROM LEAD POISONING.

Dr. OLIVER said : These kidneys and heart were removed from the body of a young man, aged 33 years, a lead miner, who was sent to the Infirmary by Dr. Robinson, of Stanhope. He first came under my care two years ago. At that time he was complaining of "dropped wrist." From this he in great part recovered. After leaving the hospital, he returned to the lead factory, where he was engaged in smelting the ore. Later on he worked the crane, and was consequently less exposed to the influence of the metal. In the early part of December, of last year, he again came under my care, complaining of great debility, transient blindness, and fits. He was much altered since I last saw him. His face was sallow and anaemic,—partly due to the lead impregnation, and partly to epistaxis, which was frequent and profuse. The gums exhibited a well marked "blue line." There was slight paralysis of the common extensors of the fingers of both hands, with anaesthesia of the back of each hand ; a loud systolic bruit could be heard over the aortic area ; the urine had a low sp. gr. (1010) and contained a very large quantity of albumen. The discs, on ophthalmoscopic examination, were found to be the seat of haemorrhages and inflammation. His blood, on microscopical examination, showed a deficiency of coloured corpuscles. From the day he came in, patient tended to become worse. The bleeding at the nose was frequent and very profuse, and the fits recurred at no great intervals, leaving him in a state of stupor and excitement, which lasted for hours after. Chloral relieved the brain symptoms, but only for a time. The anaemia increased : oedema of feet, legs, and

lungs developed, and he died comatose. At the *post mortem* the heart was found enlarged, and a small growth projected from one of the aortic cusps. The brain was markedly hydramic and anaemic. The kidneys were small and granular-looking. The capsule was firmly adherent. Under the microscope sections of the kidney exhibited the appearances met with in tubular and intertubular nephritis. There was marked increase of the connective tissue in the neighbourhood of the glomeruli, and thickening of the intertubular stroma; but in many of the tubules there was to be seen heaps of epithelial cells, many of which were undergoing fatty degeneration. The kidneys do not, therefore, present ONLY the characters of interstitial nephritis, which several writers maintain is the typical kidney lesion in lead poisoning.

#### A FAULTY TRACHEOTOMY TUBE.

Dr. HUME showed a faulty vulcanite tracheotomy tube which had been removed that day from a patient's trachea. The outer tube was screwed into the plate, and the patient had been in the habit of unscrewing it every day in cleaning the tube. In this way the screw was loosened; and one night during sleep the tube became detached, and slipped down into the trachea. The patient was admitted into the hospital, and on examination the tube was found resting at the bifurcation of the trachea. A piece of thick silver wire, bent into a small hook at the end, was used in its extraction. The wire being guided past the tube, the hook was turned so as to catch its lower edge, and it was then drawn up to the wound and seized with forceps.

#### PAROVARIAN PAPILLOMATOUS CYST.

Dr. Hume next showed a parovarian papillomatous cyst, which had been removed from a patient in the Infirmary. The ovary and tube were healthy, and were not removed. The seat of the tumour between the folds of the broad ligament was evident, and the character of the papillomatous excrescences studding the interior of the cyst wall proved its origin from the remains of the parovarium. The fluid which the cyst had contained was also shown. It was of a deep porter colour from admixture of blood, agreeing in this with the tendency which papillomatous growths everywhere have to bleed. Dr. Hume pointed out the distinction between such true parovarian cysts, and those cysts—thin-walled and containing clear limpid fluid—which are often called parovarian, but are simply broad-ligament cysts, and do not originate in the remains of the parovarium. The distinction is both a pathological and a practical one. It is only the latter—the simple broad ligament cysts—which can be and

have repeatedly been cured by a single tapping. In the case of the former, the true parovarian, it would be manifestly absurd to expect such a result. Indeed, tapping, in cases similar to the one shown, would be attended with great risk of causing dissemination of the papillomatous growths.

#### VESICAL CALCULUS FORMED ROUND A HAIR-PIN.

Dr. CAMPBELL showed a calculus which he removed from the bladder of a woman, aged 23, and said: This is a soft phosphatic calculus, and is formed around an ordinary hair-pin, which patient says she introduced into her bladder when a girl at school. Now she is 23 years of age, so it would seem that this has been lying in the interior of the bladder for at least nine years, and it does not seem to have caused much pain or inconvenience until about two years ago, when she began to complain of incontinence of urine, which condition became latterly very troublesome. On making an examination I found, about an inch below the meatus urinarius, two sharp points protruding through wall of vagina, which points I attempted at first to pull out, but found they would not move. I then dilated the meatus with my dressing forceps and introduced my little finger, and ultimately got my index finger through the meatus. I then could feel it was a calculus, and soft in character. It was adherent to the mucous membrane of the viscus, and required to be peeled off with the finger. The bladder had evidently contracted upon it firmly. I introduced the dressing forceps again, and broke the calculus down by degrees. I then pushed the free ends of the hair-pin back into the bladder, and hooked them up with my little finger until I could catch them with the forceps. I then extracted the hair-pin, from which I had previously removed all the calcareous matter, I then washed out the bladder. The whole proceeding was done without any anæsthetic, and the patient walked home afterwards. I saw her two days subsequently, when she could retain her water two hours without requiring to evacuate. I have seen her since, and she is able to retain it for a few hours without inconvenience.

In reply to Dr. Gibson, Dr. CAMPBELL said that no fistulous communication had occurred between the bladder and vagina.

#### COMBINED CIRRHTIC AND WAXY DISEASE OF LIVER.

Dr. DRUMMOND showed the liver of a young man, aged 19, who died in the Newcastle Infirmary on the 2nd February, 1885. The interest in the specimen was centred in the fact that the organ showed the combined changes peculiar to cirrhosis and waxy degeneration, the evidences of the former condition being very apparent, whilst the waxy disease, as shown by iodine reaction,

were scarcely so pronounced. The patient was admitted a few days before his death, in a remarkably debilitated and dropsical condition, the dropsy showing itself especially in the form of ascites and swollen lower extremities. There were the most pronounced signs of old scrofulous disease and congenital syphilis on the surface of the body—the former represented by healed cicatrices over both elbow and knee joints, and the latter by extensive disease of the frontal and nasal bones. Several very large venous channels coursed over the front of the abdomen, which was so full of fluid as to admit of the eliciting of fluctuation in the epigastrium as the patient lay on his back. The urine was alkaline, full of phosphates, and highly albuminous, and showed the rare condition of being so alkaline as not to throw down the albuminous cloud until acid was added. According to the history received, the patient was in tolerably good health till he reached the age of 10, when strumous sores broke out in different parts of his body; these remained open for a long time, but eventually healed, leaving him for some years in an enfeebled condition. He dated the commencement of his fatal illness a month back, when he caught cold when attending the funeral of a sister. Four days later, he began to swell in the abdomen, and in a few days subsequently the swelling was noticed in the legs. Southeys' trochars were inserted, and about 16 pints of a turbid fluid, showing a sp. gr. of 1028, neutral in reaction, and albuminous, were drawn off. He died two days later. At the *post mortem*, intense peritonitis was found, and the liver, which was enlarged (62 ounces), showed, as already stated, cirrhotic and waxy disease combined. The surface, which was covered by recent lymph, was roughened and irregular, as in early cirrhosis, and showed six or eight yellow elevated nodules, varying in size from a pea to a cherry stone, which, on section, were seen to be cheesy. On section, the substance was firm, and presented in uniform distribution a multitude of little orange-coloured marks, as in cirrhosis. Generally speaking, however, the cut surface was of a pinkish tinge, suggesting waxy disease, though in some parts this was more marked than others. Here and there, the application of iodine showed the well-known mahogany reaction. The spleen was enlarged, weighing 18 ounces. The kidneys were also enlarged, and appeared to be examples of chronic parenchymatous nephritis, though iodine detected some waxy degeneration as well.

Dr. DRUMMOND showed microscopical sections of the liver, and stated that he believed the pathological changes to be due to syphilis—this being, in fact, an example of the comparatively rare form of disease, syphilitic cirrhosis; the yellow nodules were cheesy gummata.

## EXHIBITION OF PATIENTS.

## CASE OF EMPYEMA.

Dr. PHILIPSON introduced a patient, who had been the subject of empyema, and whose case had been successfully treated by incision and drainage. The operation was performed by Mr. Page, under strict antiseptic precautions. The patient, a Dane, aged 16, was admitted into the Newcastle-upon-Tyne Infirmary, on August 27th, 1884. The dyspnoea was so urgent that paracentesis thoracis was performed the same day, when ten ounces of sero-purulent fluid were withdrawn. The operation was repeated on August 28th, when two pints were withdrawn, and again on September 9th, when thirty-four ounces were drawn off. The fluid had become purulent, and in consequence it was decided that the case was a proper one for incision and drainage. The operation was performed on September 10th, when three pints of pus were evacuated. At first, the dressing was changed daily, the amount of discharge being about three ounces; afterwards every third day, the discharge being about one ounce. The drainage tube was withdrawn on January 2nd, 1885, and the incision was healed on January 7th, when the dressings were removed and a flannel roller was applied. The temperature at the time of the operation was 105° F.; the day after the operation it was normal, and with only the occasional rise of half a degree, continued so throughout. The medicinal treatment consisted of the administration of an occasional laxative and quinine. The diet was generous, from the ordinary meat diet to the full meat diet. On February 11th the percussion note was clear, and purely vesicular respiration was heard at the left base. The heart's impulse was in its normal position, whereas, at the time of the operation, it was found beating under the right nipple. The measurement of the right chest was  $16\frac{1}{2}$  inches, at the nipple line, with half-an-inch play, on forced respiration; and of the left,  $14\frac{3}{4}$  inches, with quarter-of-an-inch play.

Mr. PAGE showed two patients who had been subjected to ligature of the femoral artery in Scarpa's triangle, for the cure of popliteal aneurism, and said: I consider myself, sir, exceedingly fortunate in being able to bring before your notice this evening these two men, who have each had the femoral artery tied, and that successfully, for the cure of popliteal aneurism within the last few weeks. Popliteal aneurism is by no means a common disease in this institution, and during the five years I filled the post of senior house surgeon, the femoral artery was never once ligatured in its continuity; and, to the best of my recollection, only one case of popliteal aneurism was admitted. It was treated

successfully under the care of Mr. Russell, by pressure. I wish this evening merely to show the patient, reserving for some other opportunity a detailed description of the two cases. I may, however, point out that in this, the first case treated, the artery was tied on January 21st, and the wound is not yet healed. Suppuration occurred and burrowed among the muscles in Scarpa's triangle. I attribute this entirely to the bruising of the tissues, caused by repeated and unsuccessful attempts to cure the aneurism by pressure. In the second case the artery was tied (Jan. 31st) for a large and rapidly-increasing aneurism, no pressure having been previously applied. The wound healed by first intention. A catgut ligature was used in each case. It is a very curious circumstance that within the last ten or twelve months the femoral artery has been tied in its continuity in the Newcastle Infirmary four times, and in addition another case of popliteal aneurism has been cured by pressure. I cannot understand why ligature of the superficial femoral at the apex of Scarpa's triangle, for the cure of popliteal aneurism, should yield such different results in the practice of the London hospitals and in that of the Royal Infirmary, Edinburgh; but so it is. Mr. Holmes, in the second edition of his "System of Surgery," quoted some statistics collected by Mr. Jonathan Hutchinson, and published during the period from 1856 to 1860, before the days of antiseptic surgery—"Out of 50 cases, 16 died, or in round numbers one-third. Mr. Bryant's tables of amputation of the thigh at Guy's for all causes, with those collected by Mr. Holmes from St. George's, give a mortality considerably under one-third." In the fifth edition of Mr. Syme's "Principles of Surgery," published in 1863, page 117, are these words: "In my own practice I have had occasion to tie the femoral artery 33 times, and never experienced any troublesome effects from the operations." In these days of antiseptic surgery, I am inclined to recommend ligature for the cure of popliteal aneurism in preference to pressure in all cases where amputation is not clearly indicated.

Mr. T. A. DODD showed a very successful case of McEwen's operation in a girl sixteen years of age. The operation was performed more than a year ago, and the legs continue perfectly straight. Also a case of nœvus of the glans penis, and there was some discussion as to what operation would be most likely to succeed in curing it.

The PRESIDENT congratulated Mr. Dodd upon the result of the operation.

Dr. FLYNN showed a case of compound depressed fracture of skull with wound of superior longitudinal sinus and hernia cerebri, in which recovery with loss of cerebral substance com-

plete aphasia and right hemiplegia had taken place, and gave the following account of the patient :—

G. F., aet about 20, labourer in one of the shipbuilding yards, was admitted into the Sunderland Infirmary, November 8th, 1883. He suffered from a compound depressed fracture of left parietal bone. His injury was caused by a blow from an iron stanchion weighing a ton.

On the morning of the 9th, the depressed bone was elevated (right hemiplegia having developed), superior longitudinal sinus wounded, from which there was an alarming amount of haemorrhage, eventually controlled by pressure with a large pad of absorbent wool.

Nov. 10th.—Right hemiplegia, loss of power over bladder and rectum, complains of severe pain in head. Relieved by 3ss doses of pot. bromidi.

11th.—No change ; wound dressed.

12th.—8 a.m. Severe haemorrhage, again stopped by pressure, but there is a great deal of serous oozing mixed with blood.

13th.—Last evening there was some difficulty in speaking ; this morning complete aphasia ; haemorrhage completely stopped.

16th.—Complete coma ; hernia cerebri.

20th.—Quite regained consciousness ; asks for what he wants ; hernia cerebri.

21st.—Wound healthy ; tries to speak, but can only make an inarticulate sound.

Jan. 2nd.—Hemiplegia improving ; wound has healthily granulated over ; but a cavity remains where the brain substance has sloughed away. Wound two-and-a-half inches in length, half inch to left of suture.

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# NORTHUMBERLAND AND DURHAM MEDICAL SOCIETY.

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THE SIXTH MONTHLY MEETING was held in the Library of the Newcastle-on-Tyne Infirmary, on Thursday, March 12th, 1885—the President (Dr. Fielden) in the chair.

The officers of the Society were nominated for re-election.

The following gentlemen were proposed for election :—

T. A. McCullagh, M.R.C.S. Eng., Bishop Auckland.

W. H. Besant, L.R.C.P. Edin., Whitley, Northumberland.

## DISCUSSION ON THE PREVALENT DISEASES OF THE DISTRICT.

Mr. HENRY E. ARMSTRONG presented the following :—

*Return of Admissions to and Deaths at the Newcastle Fever and Smallpox Hospitals during the month of February, 1885.*

Disease.	Admissions.	Deaths.
Small-pox .....	4 .....	0
Enteric Fever .....	3 .....	0
Scarlet ,,, .....	5 .....	1
Total.....	12	1

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## PATHOLOGICAL TRAY.

### GLANDULAR TUMOUR.

Mr. PAGE showed a specimen and said : These masses of diseased glandular tissue, which together make up a tumour of considerable size, and weigh  $1\frac{1}{2}$  lbs., were removed a few weeks ago from the neck of a child aged 10 years. The photographs which I hold in my hand give a good representation of the size and situation of the growth. No great difficulty was experienced in the enucleation, and a comparatively small quantity of blood was lost, but the operation was a tedious and prolonged one. The removal of the growth was undertaken in consequence of difficulty in breathing due to pressure upon the trachea, and to spasm, which occasionally was so pronounced as to threaten the child's life. The patient made a rapid recovery. Some years ago I showed here a girl from whose neck, with considerable trouble, I removed a large lympho-sarcoma, which is sufficiently well delineated in this drawing. She, too, made a good recovery, but died a few

months after with lung symptoms, due, I do not doubt, to a re-appearance of the disease in the mediastinal glande. *Vide Transactions, 1877.*

#### VESICAL CALCULI.

Dr WARDLE said : The three stones I show, I removed from a boy of 14 years of age. The chief point of interest in the case seemed to me to be that calculi of such a large aggregate bulk could be in the small bladder of a boy, who is small for his age, and produce so little disturbance as they did ; for during intervals of several weeks' duration all symptoms were quite absent, and three weeks before operating I examined the bladder carefully, under chloroform, and could find no trace of stone. On examining him again, a few days before the operation, I found it at once without any difficulty. The operation itself presented no special features ; the stones were removed with comparative ease, and the boy recovered without a bad symptom, and was walking about quite well within three weeks.

#### LEATHER STRAP PASSED BY A LUNATIC.

Dr. WARDLE, continuing, said : The strap which I show, in three pieces, I thought might be interesting, as showing what might be swallowed by lunatics with apparent comfort. The patient was an idiot of the lowest order of mind, if, indeed, he could be said to have any mind at all. The only act he seemed capable of was to turn continually round uttering discordant hoots. The strap was given him as a plaything, and was then in one piece. He contrived to swallow it one day at the commencement of May, when I happened to be in the workhouse, where he lived. I was called to him hurriedly, and found him sitting frothing at the mouth, with staring eyes, but with the strap evidently swallowed. I caused his stools to be carefully examined every day, and at the end of August the strap was passed in three pieces, having been digested through at the parts where it had been bent. The length of it was about twenty-two inches. Not the least interesting feature of the case seems to me to be, that an article which would cause the greatest discomfort or danger to a sane person can be retained for the long period of three months, without any apparent annoyance, by organs that are less "sensible."

Dr. LUKE ARMSTRONG referred to the case of a nervous gentleman who lost an upper set of false teeth. He had been under the influence of alcohol when they disappeared. An exhaustive search was made for the missing teeth, which were found, after the lapse of a few days, in the owner's rectum.

Dr. LYON referred to the case of a man who died from swallowing half a set of false teeth.

## EXHIBITION OF PATIENTS.

Dr. ARNISON showed two very successful cases of rhino-plastic operation.

Dr. BARRON showed a man upon whom colotomy had been successfully performed.

Dr. MORRIS showed a successful case of ligature of the subclavian artery for subclavian and axillary aneurism.

Mr. PAGE introduced a patient whose knee had lately been excised for disease, and said : This young woman has been under my care for about 12 months, suffering from chronic disease of the knee joint. The case was just one of those which might, I think, have been cured without any operative interference, had the patient occupied a position in life which would have enabled her to have taken the full advantage of rest with change of air, and the other ordinary methods of treatment open to a person in better pecuniary circumstances. As it was, I made a prolonged attempt to arrest the disease, applying the actual cautery, keeping the patient in bed for months, and finally sending her to the seaside in a stiff bandage. Finally, I found it necessary to excise the joint, and I wish to draw attention to the method of operating selected—one which, I believe, is advocated by Mr. Croft, of St. Thomas' Hospital. A straight incision is made across the anterior aspect of the joint, the patella sawn through with a fine saw, and the joint removed in the ordinary way. The portions of patella are then perforated with a bradawl and tied together. Stout catgut was used in this case, which I think has obvious advantages over silver wire, if it be found equally efficacious. I have used catgut for this purpose now on two occasions, and am quite satisfied with the result. I do not, however, wish it to be understood that it would be equally advantageous to ligature a fractured patella with catgut. In such a case, where it is sought to retain the action of the joint, I am of opinion that silver wire would be the best medium to employ, but upon this point I think there is room for further experiment. Experience may prove that stout catgut or tendon is sufficiently enduring, even in cases of transverse fracture of the patella.

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## THE TREATMENT OF PLACENTA PRÆVIA.

By JAMES MURPHY, B.A., M.D., &c., Surgeon to the Sunderland Infirmary; Lecturer and Examiner at the University of Durham College of Medicine, Newcastle-on-Tyne.

MR. PRESIDENT AND GENTLEMEN,—

When your Council paid me the very kind compliment of asking me to inaugurate the discussion in obstetrics, I ventured to suggest “The Treatment of Placenta Prævia” as a subject in which most of us can take part, and in which all must have an interest; for, while it is admittedly one of the most serious complications of labour, several methods of treatment have of recent years been introduced which have greatly lessened its terrible mortality, while at the same time there is by no means an unanimity among obstetricians as to what are the best means of treating the complication, and the experience of the members of this Society who have treated cases will, I trust, help us to arrive at more definite lines of treatment than at present prevail.

The placenta, I need not remind you, is said to be prævia “when it is attached to any portion of the uterus, which is subject to distention during labour” (Lusk), and has distinctive names given to it according to its relation with the internal os; thus it is said to be:—

1. *Central or complete.*—When, after dilatation of the internal os, the placenta only can be felt.

2. *Partial or incomplete.*—When, with dilated os, there is recognisable a portion of the membranes as well as a segment of the placenta.

3. *Marginal.*—When the placental border stretches down to, but not beyond, the internal os.

4. *Lateral.*—When the placenta, though attached to the spherical surface of the lower part of the uterus, does not reach the margin of the os.

To this latter class belong a great many of the cases of so-called accidental haemorrhage.

The placenta is never attached to the cervix, a fact that was first insisted on by Professor E. T. Taylor, and is now generally admitted, since Kuhn, who investigated the subject with Karl Braun, found that in no case was the placental portion, which occupied the cervical canal, adherent to the canal walls, but that in all *post mortem* examinations the remains of the placenta prævia materna ended by a sharp border line at the os internum.

The frequency of placenta prævia is variously stated by dif-

ferent investigators. Johnson and Sinclair give it at 1 in 573 (Rotunda Hospital, Dublin); Schwarz, 1 in 1,564 (among 519,328 deliveries in the Grand Duchy of Hesse); Müller, as occurring 813 times in 876,432 births, or not quite 1 in 1,000.

Lomer reports 136 cases in 6,882 births, or 1 in 50, in Schroeder's Clinic; but as this is in hospital practice, of course the per centage is too high for a general rate; but he points out that at Shrœder's Clinic and the Charité (both in Berlin) the annual number of cases is 65; and as this does not include the cases occurring in private practice, it gives the minimum of frequency in Berlin, in which the annual number of births is 46,000, so that it occurs at least once in 700 deliveries.

As regards the mortality, Churchill puts it down 1 in 3; Read, 1 in  $4\frac{1}{2}$ ; Müller at 40 per cent.; Simpson, 1 in 3, or as he forcibly puts it, greater than that of cholera or yellow fever, and double that after the operation of lithotomy. How much the mortality has been reduced of recent years by individual operators may be judged by a comparison of the following tables, which are copied from Lomer's paper in the December number of the American Journal for Obstetrics:—

#### LARGE COLLECTIONS OF CASES BY VARIOUS OPERATORS.

	NO. OF CASES.	MATERNAL DEATHS.	PER CENT.
Charpentier .....	65	22	35
Depaul .....	71	23	32
Simpson .....	654	180	29
Schwartz .....	332	80	26
Trask .....	938	237	25
Müller .....	912	212	23
King .....	240	54	22.5
Charpentier (second list) .....	952	237	25

#### COLLECTIONS OF CASES OCCURRING IN THE PRACTICE OF SINGLE OPERATORS.

	NO. OF CASES.	MATERNAL DEATHS.	PER CENT.
Spiegelberg .....	102	16	16
Barnes .....	67	6	8.5
Hecker .....	70	7	10
Murphy .....	23	0	0
Müller .....	15	0	0

In the majority of cases we have warning that the placenta is presenting, from the haemorrhages that take place towards the end

of pregnancy. These were formerly supposed to be due to the cervix casting of the placenta in the act of its being taken up and expanded during the last months of pregnancy. With a few exceptions, however, most writers have abandoned this theory, for the good and sufficient reasons, first, that the cervix does not expand so early as the floodings occur, or, indeed, until very near the end of pregnancy ; and, secondly, that the placenta is never attached to the cervix. Dr. Barnes then suggested "that the floodings occurred from detachment of the placenta, arising from an excess in rate of growth of the placenta over that of the cervical zone, a structure which was not designed for placental attachment, and which is not fitted to keep pace with the placenta. Hence, the placenta shoots beyond its site, and haemorrhage results." Now, great as is my respect for Dr. Barnes, I very much doubt if haemorrhage ever occurs from this cause. The idea that the placenta shoots beyond its site is purely hypothetical, and would apply to normally situated placentæ as well ; and, though I carefully looked for it, I never found atrophy or other indication of its having occurred in any of the cases that I have seen. Further, the bleeding would be more likely to occur at the circumference than at the centre, and would be placental and not uterine, which Dr. Barnes alleges not to be the case. I have no doubt that bleeding occurs from the four causes stated by Dr. Matthews Duncan, namely, either by rupture of an utero-placental vessel, or marginal utero-placental sinus, by partial separation of the placenta from accidental causes, such as a jerk or fall, or in consequence of uterine pains from miscarriage commencing, but being arrested at an early stage. But if we consider that contractions are frequently taking place in the uteri of pregnant women, and that these contractions have more or less of a shrinking effect on the normally placed placenta, and have a decidedly stretching effect on the placenta placed over the os, we readily perceive how liable an utero-placental vessel or sinus is to be opened, or even a portion of the placenta itself detached. Whatever be the cause, certain it is that such haemorrhages occur with great frequency towards the end of pregnancy. But I have never observed, nor do I believe, that they coincide with monthly periods as has been stated by some writers. When they occur early they generally lead to abortion, and thus indicate the proper treatment ; but, failing this, haemorrhage, occurring in the latter half of pregnancy, without apparent cause, should be regarded as in all probability the result of placenta prævia ; and on examination, should the vaginal fornix be found soft and boggy, the cervix soft, thick, and patulous, with vessels that pulsate strongly, the suspicion is increased, but though Wallace (Ed. Med. Journ. 1872) states that the placental bruit may be heard with startling distinct-

ness by means of a curved wooden stethoscope, the diagnosis is only rendered positive by introducing the finger through the os, and touching the placental mass.

When the diagnosis is thus established positively, or even when we have strong presumptive evidence of its existence, how should we proceed? This is the first point to consider in the treatment of *placenta prævia*, and it is one which I trust the members who take part in the discussion will consider the importance of; and the question at once resolves itself into whether labour should be brought on then and there, or an endeavour made to prolong the pregnancy to its normal period. The older writers recommend the latter course, and we are told to keep the patient on a hard mattress, to apply astringents and cold to the vagina, to give cold and acidulated drinks, and exhibit opium and even ergot. But though a portion of this treatment may be all very well in not at least increasing the haemorrhage, we must bear in mind that all this time the patient is in great and imminent danger. In spite of all these precautions, haemorrhage may occur at any time, and must occur when labour sets in, and we cannot foresee when it may take place, or calculate in what quantity it will pour out; and it may be, and often is, so sudden and so terrible, that death occurs before assistance can be obtained, or that the patient is so exhausted that assistance, when it comes, is powerless to save life. I would impress on this Society that the horrible mortality in *placenta prævia* is not due so much to the impotence of our art as it is to violent haemorrhage occurring before assistance can be obtained, or where that assistance is of a helpless do-nothing character. Why, then, should we hesitate to bring on premature labour at once when *placenta prævia* is diagnosed, when by means of Barnes's bags we can safely bring on labour at any time or fix the time as easily as for an ovariotomy or lithotomy, and bring a skilled assistant to help us in the operation and to share the responsibility? If this be desirable, as it is, in the case of men who make obstetrics a special study, how much more advantageous is it in the case of the immense number of practitioners who have no peculiar *penchant* for midwifery, but loathe and detest it, and merely regard its practice as one of the stern and unpleasant necessities of what we are pleased to call the noblest and most-self-sacrificing of professions. Playfair, Lusk, Barnes, and most modern writers suggest, if they do not actually advise, this active mode of procedure. But it may be objected to on the grounds that it lessens the chances of the child's life: let us see how far this holds good—Müller finds, as the result of his extensive and most important investigations, published in Stuttgart in 1877, that the haemorrhage occurs in greatest frequency from the 28th to 36th week in complete presentation, and in the incomplete varieties most frequently after the 32nd week,

and in no instance out of 912 cases that he has collected has death occurred before the seventh month. Now, though a seven months' child has not a very great chance of living (except it be a first baby, which it is notorious does excellently well), still its chances of life are not increased by the frequent floodings that are likely to occur before its birth, which will in all probability be premature, and it appears to me stands as good or a better chance by being delivered then, than by allowing pregnancy to continue, for let us consider what is the mortality of children in placenta prævia according to different authors:—

Schwarz	75 per cent.
Hecker	67 per cent.
Barnes	64 per cent.
Müller	64 per cent. (average of 2,360 cases).
Fritsch	60 per cent.
Spiegelberg	50 per cent.
Braun	50 per cent.

Now these numbers refer mostly to the question whether the child was born with life, not whether it remained alive, which is a very different matter. For example: Behm had 78 per cent. born with life, but of these only 29 per cent. lived, so that instead of having 78 per cent. of children that lived, he had in reality only 22 per cent. Kuhn followed the fate of the children in 46 cases of placenta prævia, and found that two months after birth only two of them were alive. And Müller states a placenta prævia child has only three chances out of ten of being born alive; and as Virchow shows that nearly one out of every three children born under all circumstances in Berlin die within the first year, its remaining chances would be almost gone before even its time came for measles, whooping cough, scarlet fever, and the various other diseases that we may almost regard as its necessary trials, before it reaches a time when the value of its life may be in any way compared to that of its mother; so that as far as we can at present manage the treatment of placenta prævia the chances of saving the child need not prevent us from inducing premature labour. *Therefore I would strongly urge that premature labour be brought on as soon as we know that we are dealing with a case in which the placenta presents after the seventh month of pregnancy, and even before then should the bleedings be serious, frequent, or continuous.*

Before discussing the best means of inducing labour in these cases, let us consider some of the principal methods of treatment recommended for placenta prævia, the point being to effect delivery with as small a loss of blood as possible, and with the least risk to mother and child. The older writers, even as far back as Giffard and Portal, knew that the placenta might be implanted over the os, or (as they thought) attached to the cervix; and some of their instructions for treatment are both quaint and curious, though

scarcely instructive. We find Guillemeau and Mauriceau having very clear ideas of its existence, and recommending the rapid and forcible emptying of the uterus at all hazards—the *accouchement forcé*. Rigby has written a very clear description of it in his work on “Hæmorrhage,” and appears to have been the first to have made a distinction between “unavoidable” and “accidental” hæmorrhage, and wrote that “manual extraction of foetus by the feet is absolutely necessary to save the life of the mother in unavoidable hæmorrhage, but in accidental hæmorrhage is not required.”

The first change from this method of treatment, viz., *puncture of the membranes*, is generally attributed to Puzos, but was described by Mauriceau fifty years before him, as he distinctly says: “The vessels of the uterus, which were open, become shut by the contraction of its proper substance as soon as the waters of the infant which held it extended are evacuated from it.” This practice was largely followed by Ramsbotham, and in the present day is strongly recommended by such eminent authorities as Barnes and Playfair. I have found it of service in lateral presentation, but its use in the other forms is not to be relied on. In complete presentation it is difficult of accomplishment; and besides, an objection I have to it is this, if it fails, as it often does, it renders version, which may have to be fallen back upon, more difficult and dangerous; therefore I reserve it for cases of lateral presentation of the placenta where the head presents, for when the waters escape, the head presses against the placenta, and the forceps can be applied, provided the head presents, which, be it said, it frequently fails to do in cases of placenta prævia.

The next mode of treatment which we need consider is the *separation of the placenta from the uterus*, which was so ably brought before the profession in a communication laid before the Medico-Chirurgical Society of Edinburgh in 1844 by the late Sir James Simpson. He was led to adopt this practice from a consideration of eight cases in which he found that the hæmorrhage ceased on the complete expulsion by natural means of the whole placenta before the birth of the child, and finally put on record from various sources 141 cases of this occurrence, and it may interest the Society to learn that some of these cases were contributed by the late Doctors Tulloch, Greenhow, and Hardcastle, of this city, and he arrived at the following conclusions:—

1. The complete separation and expulsion of the placenta before the child in cases of unavoidable hæmorrhage is not so rare an occurrence as accoucheurs appear generally to believe.
2. It is not by any means so serious and dangerous a complication as might *a priori* be supposed.

3. In nineteen out of twenty cases in which it has happened the attendant haemorrhage has either been at once altogether arrested or it has become so much diminished as not to be afterwards alarming.

4. The presence or absence of flooding after the complete separation of the placenta does not seem in any degree to be regulated by the duration of time intervening between the detachment of the placenta and the birth of the child.

5. In 10 out of 141 cases, or in 1 out of 14, the mother died after the complete expulsion or extraction of the placenta before the child.

6. In seven or eight out of these ten casualties the death of the mother seemed to have had no connection with the complete detachment of the placenta, or with results arising directly from it; and if we do admit the three remaining cases, which are doubtful, as leading by their occurrence to a fatal termination, they would still only constitute a mortality from the complication of three in 141, or of one in 47 cases.

7. On the other hand, under the present (1844) established rules of practice, 180 mothers died in 654 cases of placental presentations, or nearly one in three.

He first deliberately put the method in practice on the 1st of October, 1844, but the placenta had been artificially removed by others previous to Simpson, and cases are recorded as instances of malpractice by Collins, Ramsbotham, Cripps (of Liverpool), Lowenthal, Baudelocque, &c. Ramsbotham describes a case so graphically that it is worth recording in his own words. He was summoned by a doctor to come and help him in a case he was attending, but before Ramsbotham left his house he received a second message from the doctor saying that he need not come, "as the woman was better and doing well." When on next meeting the doctor he asked what was the nature of the case, the following conversation ensued. "It was the strangest case I ever saw; it was a placental presentation with the most violent flooding, but I got it away." "Got what away," says Ramsbotham. "Why the placenta," says the doctor. "What, before the child?" asked Ramsbotham in astonishment and horror. "Yes, before the child," said the doctor, "and the flooding ceased and the woman did well, and the child soon followed the after-birth." Simpson thought the placenta was the source of the bleeding; this, however, has now been established not to be the case, as the haemorrhage comes from the open mouths of the uterine vessels, and Barnes has drawn attention to the fact that in the majority of cases it is not necessary to separate the whole placenta, for there is a natural spontaneous arrest of haemorrhage attained when that part of the placenta which has grown within the lower zone has been detached, provided uterine contractions

concur, for it is on these we must depend to stop the haemorrhage ; and the reason of the cessation of haemorrhage, though not explained by Barnes, is, I believe, this—when the placenta is completely expelled, the uterus is able to contract and close the open mouths of its vessels, as it does in twins, where the first placenta is expelled before the birth of the second foetus ; but when the placenta is only slightly detached, the connecting vessels being only partially torn are kept on the stretch, and so the chief source of the haemorrhage is from the line of juncture of the uterus and partially-detached placenta ; but when the placenta is sufficiently detached to become flaccid it does not drag on the vessels, and so permits them to contract, which they readily do provided the uterus is contracting, hence it is desirable to pass in a finger and separate the placenta well round the os to permit this flaccidity to occur. The extent to which this should be done will vary in different cases, depending on various circumstances, such as position of the foetus, amount of liquor amnii, strength of pains, &c., but it generally corresponds to the extent which the placenta would be spontaneously detached to admit the passage of the foetal head, the largest circumference of which is about equal to a circle with a diameter of  $4\frac{1}{2}$  inches ; or, according to Matthews Duncan, the plane at which spontaneous detachment ceases is reached at a distance of  $2\frac{1}{2}$  inches by following the curve of the lower segment, and of  $1\frac{1}{2}$  inches if measured in the plane of the uterine axis.

The next treatment which we need consider is the *tampon*. Now though it is still recommended by several eminent obstetricians, including Lusk and Playfair, I would suggest that the day of the *vaginal* plug is gone—it is out of date—it is now as unscientific in principle as it was unsafe in practice ; it was unreliable in controlling haemorrhage, and was a most fertile source of septicaemia. What is required is a method which will control the bleeding and at the same time hasten labour, and nothing that I am acquainted with answers these requirements so thoroughly as Barnes's hydrostatic bags, or (as I prefer) Steele's modification of them ; and Braun, after many years' experience at Vienna with the colpeurynter maintains the superiority of hydrostatic dilatation, therefore I will not take up your time by discussing the various means which have been adopted for plugging the vagina, but may remind you that should you not have time from the urgency of the case to get Barnes's bags, as once occurred to me, a very efficient cervical plug can be made by the hand, the fingers being joined together in the form of a cone.

The method of Jungbluth, which consists in *the dilatation of the cervix with sponge tents*, I see no advantage in, except that it may be required preparatory to the introduction of a small-sized bag ; but I have never had occasion to have recourse to it, as in all

the cases I have seen the os has been, if not patulous, at least sufficiently dilatable to admit the finger, with a little patience, to be gently introduced and thus prepare the way for a bag.

The local application of *styptics* I will not stay to discuss—I have no faith in them—but will pass on to the consideration of *version*—(1) external version, both hands being employed on the abdomen; (2) internal version, by means of a hand being introduced into the uterus; and (3) the combined method (the method of Braxton Hicks), when a finger or two are introduced through the os and the other hand is used on the abdomen. Now nearly all the older writers practised version, and this they generally did by forcing the hand through the cervix, seizing a foot, turning the child, and pulling it through the os as rapidly as possible, utterly regardless of the condition of the cervix and os; in fact the quicker they did it the more they prided themselves on their skill. Well, this was a most disastrous proceeding, and to its continuance may be traced many of the deaths still occurring. The cervix, from its congested and increased vascular condition, is more likely to be torn than in ordinary labour, and a laceration is then more dangerous, not only from the immediate production of haemorrhage, but from its increased liability to septic absorption. Most writers strongly condemn it, and justly so. External version, as first performed by Wigand, has not been much used; it is in most cases difficult to perform, and having been performed, it would still be useless until the fingers were introduced and a leg brought down. Internal version is often of very great benefit when it is judiciously performed with a fully dilated or easily dilatable os, and has been very extensively employed, and still continues to be so, as the bi-polar method, for some reason or other, has never been taken to kindly in England, the country of its invention. It seems to have been performed by Hamilton in 1822, by Lee in 1843; but was first brought prominently before the profession by Braxton Hicks, in a communication to the *Lancet*, on July 14th and 24th, 1860, in which the treatment of five cases of placenta praevia by this method was described; and the subject was more fully treated in a most able manner in a paper read by him at a meeting of the Obstetrical Society, on the 4th November, 1863. Dr. Barnes (the president, in the chair) spoke in very flattering terms of its advantages, as did also Baker Brown, Hall Davis, Greenhalgh, Graily Hewitt, and others.

It has not even up to now taken much hold in America, as King, in the collection of cases occurring in the State of Indiana, found that it was only practised 1 in 240 cases, and the treatment recommended by Lusk in his recent text-book differs essentially from the method of Hicks, as he says: “When the cervix has been sufficiently stretched by dilators to admit of delivery, the finger

should be introduced, the placenta should be separated, the membranes ruptured, and an extremity seized without passing the entire hand into the uterus. Extraction should follow—the pressure of the foetus prevents any considerable amount of haemorrhage."

In France, it does not seem to have taken hold even at the present day, thus Wasseige (1881) only mentions it in remarking that "its application is limited to rare cases, for should it not succeed, we would render ordinary version more difficult—the membranes being ruptured by the attempt," and Charpentier, in his new and extensive text-book, published in 1882, does not even mention it in connection with the treatment of *placenta praevia*.

It was at first rejected in Germany, more especially by Hecker, Spiegelberg, and Müller; but it slowly made its way, and is now warmly advocated by several, including Hoffmeier, who was the first to give it an extensive trial in hospital practice, then by Behm, Schmidt, Lomer, Kuhn, Fasbender, Martin, and Kaltenbach. And as Lomer has recently gone so fully into the question in the paper before alluded to, I cannot do better than describe in his own words the method as practised in Schröder's Clinic in the University Hospital for Women in Berlin. "Turn by the bi-manual method as soon as possible, pull down the leg and tampon with it, and with the breech of the child the ruptured vessels of the placenta. Do not extract the child then; let it come by itself, or at least only assist its natural expulsion by gentle and rare tractions. Do away with plug as much as possible; it is a dangerous thing, for it favours infection, and valuable time is lost with its application. Do not wait in order to perform turning until the cervix and os are sufficiently dilated to allow the hand to pass. Turn as soon as you can pass one or two fingers through the cervix. It is unnecessary to force your fingers through the cervix for this. Introduce the whole hand into the vagina, pass one or two fingers through the cervix, rupture the membranes, and turn by Braxton Hicks's bi-manual method. Use chloroform freely in performing these manipulations. If the placenta is in your way try to rupture the membranes at its margin; but if this is not feasible, do not lose time—perforate the placenta with your finger, get hold of a leg as soon as possible and pull it down. This may cause a very strong haemorrhage at the moment. Hofmeier and Behm have already remarked this, and I can fully confirm their observation. This is the only critical moment in the operation. The operator must be prepared for it, and must not lose his presence of mind when his hand is suddenly covered with a stream of blood. He must remember that the most alarming haemorrhage will cease with positive certainty when he pulls down the leg of the child. Up to this moment the treatment is an energetic, active one. Experience shows that flooding now ceases. The next part of the treatment

is of an expectant nature. A quick extraction made now would cause rupture of the cervix, and fatal post partum haemorrhage. Wait, therefore; give the patient time to rally her powers; wait until pain sets in, and then assist nature by exerting slow and gentle tractions; if the child is in danger during this time, let it run its risk, let it die if necessary, but do not endanger the mother by quick extraction. Cervical laceration is always a dangerous thing—it is particularly dangerous in placenta praevia, on account of the great vascularity of the tissue of the cervix and its liability to rupture. Atony of the uterus is also a disagreeable complication, especially in cases of placenta praevia, when there generally is not too much blood to lose; but these dangers may be got rid of by an expectant treatment. After turning, pains generally set in quickly, the cervix distends rapidly, and the child is born generally between one and two-and-a-half hours after turning."

He then discusses the method under five heads:—

1. How should we treat cases of flooding occurring during pregnancy? and states that his cases have not proved to him the necessity of bringing on premature labour, but goes on to say, "when strong haemorrhage occurred in pregnancy, we use the tampon and examine a few hours later, to see whether the cervix was sufficiently dilated to allow one finger to be passed, and to permit of turning to be performed." In this sense, he confesses, his method may be counted perhaps among the proceedings having the object to induce premature labour in placenta praevia, and further says "operators who have lately followed this plan have had very good results," paying me the compliment of quoting me as an exponent of it, saying that my cases "show that the adoption of active measures early is the right thing for placenta praevia."

2. Is bi-manual turning an easy operation? To which he answers in the affirmative—in which all who have practised the method frequently will concur—and recommends chloroform to be freely given in all cases.

3. Can we rely on haemorrhage ceasing after turning? Replying, that notwithstanding all views to the contrary, that it is a matter of fact that haemorrhage does cease.

4. How long must we wait for the child to be born by natural powers? That delivery takes place in from one to two-and-a-half hours. Behm generally allows the children to be born quite spontaneously, and had to wait from half-an-hour to four hours, and in one case for eleven hours.

5. Ought the method of rupturing the membranes in head presentation be abandoned altogether? He says circumstances must decide. When the placenta is only felt marginally, when the head has entered the pelvis, when pains are strong and haemorrhage not very profuse, then rupture of the membranes seems to be the right

thing. It must not, however, he says, be forgotten, that in adopting this method of treatment the chances for effecting an easy version are lost; and as sometimes haemorrhage does not cease after rupture of the membranes, turning has then to be resorted to under unfavourable circumstances, and approvingly quotes King, who says "that the evacuation of the liquor amnii, if performed before the os is dilated, is an unreliable agent, and ought not to be classed as a means for controlling the haemorrhage."

I have thus quoted very fully from Lomer, as he represents one of the greatest midwifery schools in the world; and the treatment he recommends has had such extraordinary success in Germany that I am anxious that it should be placed before the Society in the words of one who has had a large experience of it, more especially as I have never had recourse to it, the results of the methods which I practise having hitherto been so good that I am loath to leave them, and I am strongly inclined to believe they more fully prevent haemorrhage and give the child a better chance.

The practice which I follow consists, not in a single method for stopping haemorrhage, but in several, and it is this: In the first place in every one of my own patients, or in those that I am consulted about, when haemorrhage occurs after the seventh month, when it is clearly not from the cervix or os, and when there is presumptive evidence that it is from placenta prævia, I advise premature labour to be induced, or before that period of pregnancy when the haemorrhage is severe, continuous, or frequently recurring. In cases that permit of a little delay from the symptoms not being very urgent, I appoint a time when I can give a few hours continuous attendance—two hours is generally sufficient; as once you commence to induce labour, I consider it necessary to remain with the patient until delivery is accomplished; and when the case does not command instant action one can fix his own time and can have what assistance he requires.

I find having an assistant a great advantage, and by thus arranging a definite time practitioners can secure the services of a specialist or fellow practitioner to help them and share the responsibility. On examination, if the cervix will permit it, I introduce my finger, separate the placenta all round, as far as my finger will reach, and then put in a Barnes's bag; and if not, I gently and slowly insinuate my finger through the os, which I have always found easy of accomplishment, never having had recourse to the preliminary introduction of a tent, though in inducing premature labour for other causes I have frequently had to introduce tupulo tents, having thus dilated the cervix with my finger, I separate the placenta freely around the internal os, and at once introduce a Barnes's bag. I slowly fill it with

water---and here let me give a practical hint on the use of hydrostatic bags, which I do not remember to have seen mentioned in any of the text books: When the bag is well through the cervix it is very difficult to say how full it is, and by continuing the injection it may very easily be burst, as once happened to myself, and has, I know, happened to many others; so to avoid this it is desirable to ascertain and remember how many syringefuls each bag requires before being fully dilated, and then to carefully inject only that number. Having thus filled the bag, I wait patiently until the os is well dilated around it, and, before introducing another one, separate the placenta further should the haemorrhage continue, which it does not provided the placenta has been sufficiently separated at first. After the bag has been introduced for some time the pains come on fairly well, though as a rule they are not very strong.

I thus proceed until the os is fully dilated, when I give ergot freely and decide what is the most suitable course to follow. If the placenta is lateral or marginal, and the pains fairly strong, I rupture the membranes and leave the case to nature; or if the head is well into the pelvis, I may apply the forceps; but in the great majority of cases I perform version, preferably by the combined method, and deliver the child as quickly as is consistent with safety to the mother. Bearing in mind that the os is now fully dilated, this practice is essentially different from the old *accouchement forc *.

If I may offer a suggestion as to the course to be followed in the discussion, it is this---

1st. How are cases of flooding from placenta pr via to be treated during pregnancy?

2nd. Is labour to be induced—if so, when and how; if not—what treatment should be followed?

3rd. What is the best method of conducting the labour so as to stop the haemorrhage and give the best chance to the mother and child?

This latter question is one which is preeminently deserving of the attention of the Society, as in all the methods I have discussed the mortality to the children is very great.

In conclusion, sir, I beg to thank you and the members for the patience and attention with which you have followed my rather lengthened remarks, and I have much pleasure in presenting to the Society a complete list, drawn up in tabular form, giving particulars of all the cases of placenta pr via I have seen, 23 cases without a single maternal death.

Dr. NESHAM said: Mr. President and gentlemen,—I have listened with great pleasure to Dr. Murphy's most able paper on

"Placenta Prævia." There is no subject in the wide range of obstetrics so pregnant with interest to the practitioner, or so vital in its importance to the patient, as the thorough knowledge of the pathology and treatment of placenta prævia; and I may here state, that I believe there is no obstetric complication in which the treatment has so improved in late years, as in the condition under consideration to-night. The old highwayman's motto of "turn and deliver" in every case is now no longer acted on; and the more we see, and the more we read of cases of placenta prævia, the more we recognise that it is not always necessary, at once, to push our hand through the cervix uteri, turn the child, and deliver by accouchement forcé. The first writer to point out the error of this plan of treatment was undoubtedly Dr. Barnes, who clearly, logically, and statistically proved that there was a *stage* in labour complicated by placenta prævia, uninterfered with by treatment, in which the haemorrhage ceased—viz., when the cervix was dilated to a sufficient extent to admit the passage of the foetal head; and as Dr. Murphy tells us, if you separate the placenta to that extent from the uterine wall—rupture the membranes—bring down the head by external pressure, administer ergot to maintain uterine contraction, the labour will often terminate naturally. I believe this is not only perfectly possible, but is absolutely the correct plan of treatment, assisted, if need be, by the dilating power of Barnes' bags and the timely use of the forceps. Should any mal-presentation of the foetus occur, still bi-polar version may be adopted without forcing the hand into the uterus, and thus the danger of shock and cervical lesion be avoided. But I would now turn from the question of the treatment of labour at *full term* complicated with placenta prævia, to that of the treatment of haemorrhages in the latter months of pregnancy. I take it from Dr. Murphy's paper, that when these occur due to placenta prævia, the exact condition of matters is *always* easily diagnosed, and that premature labour should at once be induced. Here I must join issue with my friend Dr. Murphy. I grant and uphold that if alarming flooding occurs in the latter months of pregnancy, and through a patulous cervix a placental presentation be diagnosed by the "finger," then certainly all conventional means of allaying haemorrhage should be put to one side, and a pregnancy so fraught with danger should at once artificially be brought to an end. It is useless to speak of the child's life. It has ever been an axiom in British obstetrics that the child's life must not weigh for one moment in the balance against the life of the mother; and even in such a case, if the pregnancy has advanced to the seventh month, the child has a better chance to live than if left to run the gauntlet of repeated haemorrhages and forced delivery. But what I wish this evening to state deliberately is, that I do not agree

with my friend Mr. Murphy, when he tells us that in all cases of haemorrhage in the later months from placenta prævia the presentation can be detected by the finger. I know that it has been suggested to diagnose it by vaginal stethoscopy. I have not practised this art myself, and I must still trust to my finger alone, and not my ear, for a correct diagnosis in such cases. As examples of this difficulty, let me give you briefly the outlines of two cases which occurred in my practice last year:—

No. 1.—A lady in her ninth pregnancy had, unwarned, a severe flooding at the end of the seventh month. It had ceased when I saw her, and on examination os and cervix were closed. No digital examination could detect the presentation. At the end of the eighth month, another unwarned flooding took place. Again digital examination revealed no presentation. I felt sure it was a case of partial placenta prævia, but in consultation with the regular medical attendant, an exceedingly good accoucheur, it was decided to wait and watch. At her full time, labour came on with excessive flooding, and proved one of the worst cases of placenta prævia I ever attended. The child was still-born, and the patient made a very tardy recovery. Dr. Murphy will tell me that I ought to have induced labour a month before, and so I would, could I have detected the prævial presentation, but I could not, nor could her own medical man—the os was closed. Now, let me relate case

No. 2.—A lady in her third pregnancy, a near relation of an obstetrical practitioner, a friend of mine own, had a severe flooding at the end of the seventh month, whilst at her toilet. She never told me, but spoke the next day to her relative about it. He came down to my house in hot haste and asked me to induce labour at once. To this I demurred, but he enforced it by asking me if I had not read Dr. Murphy's paper in the British Medical Journal. For the moment I quite forgot the shining light who presides over matters surgical and obstetrical in Sunderland, and replied I had not. He then adduced the argument we have heard to-night, but, unimpressed, I refused to do anything until I had made a careful vaginal examination, which in these cases must always be insisted on. This I did next day, and failed to detect any placental presentation. I declined to interfere, as I looked upon the case as one of accidental haemorrhage. The patient went to her full time, and had an easy and natural confinement.

Now, the inference I wish to draw from what I have said is this: given flooding of a dangerous nature in the latter months of pregnancy, especially if repeated and through a partially-dilated cervix, a placental presentation can be detected by the finger; then by all means at once induce premature labour and conclude the pregnancy—do not leave your patient in a condition of immi-

nent peril. But if a flooding has occurred and you cannot make out the presentation with your *finger*, you have no right to conclude by vaginal stethoscopy, or by imaginary pulsations not synchronous with the mother's pulse, that *prævial* presentation is present, and proceed to take nature unawares, at the risk of the mother's life and the child's existence.

Dr. BRADLEY said : I think, sir, the Society is much indebted to Dr. Murphy for his very able and exhaustive paper, in which all that is known on the subject is clearly stated. I have practised almost all the various methods inculcated in the paper during a period of sixteen years, and embracing a number of cases averaging over three hundred a year. No one method of treatment can be pursued in all cases, but that mode of treatment is the best which is attended by the best results. Of all the methods, that which I most frequently adopt is version, by the bi-polar or bi-manual method. For dilating the os uteri, there is nothing equal in my opinion to the educated and sensitive hand introduced in the form of a cone, with an onward and sweeping round movement. My remarks apply to the full term of utro-gestation. Having pushed the hand through the os, the plan is to seize and bring down a foot, which is the best tampon ; bleeding is thus completely arrested, and delivery can be speedy or otherwise as the exigencies of the case demand. A good deal has been said about the danger of thrusting the hand through an undilated cervix. Now, you cannot thrust the hand through an undilated cervix. The limited time at my disposal prevents me from referring to the treatment of hæmorrhage prior to the full term.





Dr. MURPHY'S TABLE OF TWENTY-THREE CASES OF PLACENTA PRÆVIA.

Case.	Patient's Age.	Number of Pregnancy.	Usual Medical Attendant.	When first seen.	Amount and Duration of Hæmorrhage before Treatment.	State of Os when first seen.	Presentation of Placenta.		Result to Mother.		Date.
							Placenta.	Fetus.	Mother.	Cid.	
1	27	3rd	Midwife . . . . .	6½	Very faint . . . . .	Closely contracted . . . . .	Margin.	Head . . .	Dilatation of os; separation of placenta; version.	Recovered	Dead . . . Dec. 4, 1877.
2	29	4th	Dr. G. Welford..	8½	Extreme collapse; convulsions from loss of blood.	Fully dilated; in labour	Complete	„	Hand passed by side of placenta; foot immediately seized; version.	„	Mar. 12, 1878.
3	35	6th	Dr. Berwick . . .	5	Pale, and very faint	Severe flooding for two hours.	Fully dilated; in labour	„	Labour-pains very violent, which rapidly expelled both placenta and foetus naturally.	„	Sep. 14, 1878.
*4	32	7th	Midwife . . . . .	Last	Completely blanched, and in an extreme state of collapse.	Great loss on commencement of labour; two previous floodings.	Size of florin; easily dilatable.	„	Barnes's bags; separation of placenta; version.	„	Mar. 5, 1879.
5	37	11th	Dr. Maling . . .	Last	Great faintness . . . . .	Dilated fully; in labour	„	„	Hand passed by side of placenta; foot seized; version.	„	Sep. 28, 1879.
6	42	1st	Dr. Morgan . . . . .	Last	Fairly good . . . . .	Great loss intermittingly for three days while labour was going on; four previous floodings.	„	„	Barnes's bags; dilatation very slow; separation of placenta; Tannier's forceps first, then Barnes's forceps.	„	Mar. 25, 1881.
7	26	3rd	Dr. Morgan . . . . .	Last	Very good . . . . .	Slight haemorrhage on commencement of labour; two previous floodings.	Size of half-a-crown; rigid and unyielding; in labour.	Partial	Barnes's bags; dilatation rapid; separation of placenta; pains strong, and labour quickly completed naturally.	Alive . . .	Mar. 31, 1881.
8	34	5th	Dr. Murphy . . . . .	Last	Very good . . . . .	A sudden and severe gush of haemorrhage occurred an hour before I saw her.	Size of shilling, and dilatable.	Complete	Barnes's bags; separation of placenta; forceps.	„	Dead . . . June 21, 1882.
*9	32	7th	Dr. Murphy . . . . .	Last	Very good . . . . .	Severe on commencement of labour; no previous flooding.	Size of shilling; rather rigid.	Partial	Digital dilatation; separation of placenta; version.	Alive . . .	Aug. 1, 1882.
10	37	14th	Dr. Maling . . . . .	6	Very faint, and blanched.	Hæmorrhage had been going on, more or less severely, for previous six weeks.	Would admit tip of finger; rather rigid.	Complete	Barnes's bags; separation of placenta; all haemorrhage ceased; foot brought down; fetus dead and putrid; traction.	„	Dead . . . Oct. 20, 1882.
11	32	4th	Dr. Bernard . . .	8½	Very good . . . . .	Once, a fortnight before; no recurrence.	Would scarcely admit tip of finger; dilatable.	Head . . .	Labour induced by digital dilatation; separation of Barnes's bags; separation of placenta; version.	Alive . . .	Nov. 1, 1882.
12	43	7th	Dr. Bernard . . . . .	7	Blanched . . . . .	More or less continuous for a fortnight.	Would admit tip of finger; dilatable.	„	Same as last case; version.	„	Feb. 6, 1883.
13	37	7th	Midwife . . . . .	Last	Fairly good . . . . .	Slight; one previous flooding.	Size of shilling; dilatable.	Margin.	Barnes's bags; separation of placenta; version.	„	Mar. 2, 1883.
14	20	1st	Dr. Murphy . . . . .	5	Very faint . . . . .	Very severe for four hours.	Size of shilling; dilatable.	Complete	Digital dilatation; separation of placenta; version.	„	Dead . . . Mar. 8, 1883.
15	40	9th	Dr. Beattie . . . . .	8	Very faint . . . . .	Very severe for two hours; one previous flooding.	Size of half-a-crown; dilatable; in labour.	Shoulder	Barnes's bags; separation of placenta, which was pushed to one side; forceps.	„	Apr. 26, 1883.
16	32	4th	Dr. Fell . . . . .	8	Good . . . . .	Slight for two hours . . .	Would admit tip of Latr. finger.	Latr.	Barnes's bags; rupture of membranes.	Alive . . .	Aug. 30, 1883.
†17	36	5th	Dr. Beattie . . . . .	8½	Blanched and very faint.	Three previous floodings.	Would admit finger . . .	Complete	Barnes's bags; separation of placenta; version.	„	Sep. 23, 1883.
18	40	7th	Dr. Bernard . . . . .	8	Very much blanched.	Several previous floodings.	Would admit tip of finger.	„	Barnes's bags; separation of placenta; version.	„	Jan. 20, 1884.
19	35	6th	Dr. Morgan . . . . .	8½	Very faint . . . . .	One slight previous flooding.	Would admit tip of finger.	„	Barnes's bags; separation of placenta; version.	„	Mar. 1, 1884.
20	40	5th	Dr. Bernard . . . . .	8½	Faint . . . . .	One previous flooding . .	Would admit goose quill.	„	Os dilated with finger; Barnes's bags; separation of placenta; version.	„	Apr. 11, 1884.
21	41	12th	Dr. Beattie . . . . .	8	Blanched and almost pulseless.	Several severe floodings..	Size of shilling. . . . .	„	Separation of placenta; Barnes's bags; separation of placenta; naturally.	Dead and putrid	May 20, 1884.
22	34	5th	Prof. Brady . . . . .	6	Very good . . . . .	Two slight bleedings . .	Fully dilated. . . . .	Partial	Placenta expelled naturally.	Dead . . .	June 25, 1884.
23	28	4th	Dr. Dixon . . . . .	7	Very good . . . . .	One slight bleeding . .	Would admit tip of Latr. finger.	Latr.	Barnes's bags; rupture of membranes.	Alive . . .	Dec. 28, 1884.

\* Phlegmasia alba dolens. † Narrow conjugate diameter; version performed in all labours; only one other child born alive.

‡ Had placenta prævia in her last labour.

In all the cases, as soon as the placenta was separated sufficiently, the haemorrhage ceased completely, or became so very trivial as to be of no consequence.





